1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

Patient Information Form

The Zanesville Medical Center is pleased to provide to our patients the Synergy Medical Weight Loss program. Please fill in the fields below.

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____ SS#:_____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Work/Cellular: _____

Date of Birth: _____Age: _____ Sex: M F

E-Mail Address: _____

Do you have health insurance? __Yes __No Name of insurance: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone No: _____ Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Who may we thank for referring you to us? _____

Financial Policy:

Thank you for selecting Zanesville Medical Center Weight Loss for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements or payment plan have been made. For your convenience, we accept Visa, MasterCard, American Express Check and Cash. Payment Plans require a credit card on file for Auto Pay Debit according to your plan you have selected.

I have read and understand all the above and agree to the terms set forth.

_____ _____

Patient's Signature Date

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No

3. Are you taking any medications at the present time, including beta blockers, heart or pain medications? Yes No

If so, please list: _____

_____

4. History of Constipation (difficulty in bowel movements) Yes No

5. History of Frequent Headaches? Yes No

6. Migraines? Yes No

7. Do you smoke? Yes No

8. History of Heart Attack or Chest Pain? Yes No

9. Any allergies to any medications? Yes No

10. Do you suffer from allergies Yes No

11. History of Glaucoma? Yes No

12. History of High Blood Pressure? Yes No

13. History of Swelling Feet? Yes No

14. History of Diabetes? Yes No

15. History of Sleep Apnea Yes No

16. Serious Injuries? Yes No

17. Any Surgery? Yes No

If so, please list: _____

_____

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

Female History:

18. Menopause	Yes No
19. Average Cycle Duration (in days)	_____
20. Are you regular?	Yes No
21. Pain Associated?	Yes No
22. Last Menstrual Period	____/____/____
23. Birth Control	Yes No
24. Last Annual Exam	____/____/____

(**Check all that apply**)

_____Low Libido	_____Lack of Energy	_____Decreased Strength
_____Decreased Muscle Mass	_____Sleep Disturbances	_____Hair Loss
_____Poor Memory/ Concentration	_____Sadness	_____Decreased Enjoyment of Life

Past Medical History: (Check all that apply)

_____ HIV	_____ Kidneys	_____ Liver Disease
_____ Lung Disease	_____ Bleeding Disorder	_____ Eating Disorder
_____ Arthritis	_____ Alcohol Abuse	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Cancer	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Other: _____	

Family Medical History: (Check all that apply)

_____ High Blood Pressure	_____ Nervous Breakdown	_____ Heart Trouble
_____ Cancer	_____ Strokes	_____Anemia
_____ Obesity	_____ Kidney Disease	_____ Suicide
_____Migraine	_____ Allergy	_____ Bleeding (abnormal)
_____ Arthritis	_____ Epilepsy	_____ Syphilis or bad blood

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

Nutritional Evaluation:

25. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

26. In what time frame would you like to be at your desired weight? _____

27. What is the main reason for your decision to lose weight? _____

28. When did you begin gaining excess weight? (Give reasons, if known)_____

_____

29. What has been your maximum lifetime weight (non pregnant) and when: _____

30. Previous Diets you have followed: _____

_____

31. Give dates and results of previous weight loss attempts: _____

_____

32. Is your spouse, fiancée or partner overweight? Yes No

33. Do you awaken hungry during the night? Yes No

34. How often do you eat out? _____

35. How often do you eat "fast foods"? _____

36. Do you wake up in the morning hungry? Yes No

37. What time of the day are you most hungry? _____

What is your activity level?

_____ **Inactive-** No regular physical activity with a sit down job
_____ **Light activity**- No organized physical activity during leisure time
_____ **Moderate Activity**- Occasionally involved in activities such as weekend gold, tennis, jogging, Swimming or cycling
_____ **Heavy Activity-** Consistent lifting, stair climbing, heavy construction, etc., or regular participation In jogging, swimming, cycling or active sports at least three times per week
_____ **Vigorous Activity**- Participation in extensive physical exercise for at least 60 minutes per session 4 Times per week

38. On average how many hours of sleep do you get per night? _____

1400 Brandywine Boulevard
Zanesville, OH 43701
Phone: 740-450-9000
Fax: 740-450-2494

Weight Loss Program Consent Form

I _____ authorize Zanesville Medical Center and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal. Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and I realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever are concerning the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Please Note: Signing this form in no way obligates you to participate in the program.

Date: _____ **Time:** _____

Witness: _____ **Patient:** _____
(or person with authority to consent for patient)